EMS OFFICE USE ONLY
Received:
Issued:

APPLICATION FOR CERTIFICATION AS AN "OUTSIDE HOSPITAL"
EMERGENCY MEDICAL SERVICE

CRITICAL CARE AIR AMBULANCE SERVICE

1. SERVICE INFORMATION

Legal Name of Service: _____

Medicare Number: (Optional): _____

ADDRESS	
Mailing	All Geographic/Physical Locations

Head of Service: _____ JobTitle: _____

Telephone of Head of Service: Office:_____
Home:_____
Fax (Business): _____
e-mail contact: _____
Web site: _____
24-hour Dispatch number:_____ ☐ 911 ☐ E-911

2. CONTINUING AEROMEDICAL EDUCATION

Name of person(s) responsible for continuing aeromedical education program:

#	Name	Contact Telephone
a.		
b.		
c.		
d.		

3. PHYSICIAN MEDICAL DIRECTOR

List all physicians who are qualified under 7 AAC 26.630 and who agree to fulfill the responsibilities outlined in 7 AAC 26.610 - 7 AAC 26.690. (If your service has more than two physician medical directors, provide information for each.) If your physician medical director is affiliated with the Public Health Service or the military, please indicate state(s) of license and license number. The physician medical director(s) must sign below before the application is submitted.

By my signature below, I verify that I will fulfill the requirements in state regulations 7 AAC 26.610-7 AAC 26.690, including annual review of treatment protocols (standing orders). I further verify that the listed personnel have completed the aeromedical training as required in state regulations.

A. _____

Printed Name AK License # Signature

_____ Board Certified? Yes ☐ No ☐

Specialty Training Board Eligible? Yes ☐ No ☐

_____

Aeromedical Training Training Organization Date Completed

_____

Aeromedical Training Training Organization Date Completed

B. _____

Printed Name AK License # Signature

_____ Board Certified? Yes ☐ No ☐

Specialty Training Board Eligible? Yes ☐ No ☐

_____

Aeromedical Training Training Organization Date Completed

_____

Aeromedical Training Training Organization Date Completed

C. Date physician-signed standing orders were last: _____ _____

by physician. Reviewed Revised

4. INFLIGHT PATIENT CARE FORM

If you do not have an EMS report form which meets state requirements, the Alaska Critical Care Air Transport Form (#06-1467) may be obtained from the EMS Unit at P.O. Box 110616, Juneau, AK 99811-0616. Check the appropriate box regarding your EMS inflight Patient Care Report Form:

☐ Enclosed Own Report Form ☐ Service uses Alaska Critical Care Air Transport Form

Send me _____ Alaska Critical Care Air Transport Forms.

5. LICENSED PERSONNEL

List all licensed personnel, such as Mobile Intensive Care Paramedics, Physician's Assistants, Nurse Practitioners, Registered Nurses, or Certified Emergency Nurses, Critical Care Registered Nurses, or Physicians involved in the transportation and care of patients. (Indicate name, certificate or license number, status, and aeromedical training status.) If personnel are recertifying with the service, they must have had 16 hours, per certification period, of continuing medical education (CME) in specialized aeromedical patient transportation topics.

Name	Level of License	State License & Number[1]	Expiration Date	Date of Initial Aeromedical Training[2]	# Hours of Aeromedical Training in Last 2 Years & Dates of Training [2]

[1] If the air ambulance service is not based in Alaska, please list the state of licensure and license numbers.

[2] This refers to department-approved training in accordance with 7 AAC 26.330 (c)(3).

6. EQUIPMENT INFORMATION

A. Please verify with a check mark that your service has the following equipment and will carry it on the aircraft, when appropriate. The following is a list of the appropriate equipment to perform advanced life support medical procedures within the skill levels of available licensed personnel. Brand names as stated are used for identification of type. This does not imply endorsement by the American College of Surgeons or the State IPEMS Section. This equipment may be packed or grouped as desired. **Please note that this is not a list of required equipment; rather, it is an inventory of ALS equipment carried by your service which allows personnel to provide emergency medical care in accordance with its physician-signed standing orders.**

RESPIRATORY AIRWAY PACK

- ☐ 1 knife and sterile blade
- ☐ 1 large Kelly clamp
- ☐ 1 suture - 0 silk on curved needle
- ☐ Nasogastric tubes (including 8-16 F)
- ☐ 1 60cc syringe (catheter tip)
- ☐ 1 chest decompression flutter valve with rubber tubing (three-way stopcock)
- ☐ 1 laryngoscope-adult and pediatric (straight and curved blades)
- ☐ Extra light and battery
- ☐ 1 each chest tubes #20/32-36
- ☐ 1 viscous lidocaine HCL 2% 100 ml
- ☐ 1 surgical lubricant
- ☐ Pediatric and adult Magill forceps
- ☐ 1 10cc syringe
- ☐ Oral airways #00-5
- ☐ Rigid suction tip (e.g., Yankaur)
- ☐ Endotracheal tube stylets – adult and pediatric sizes
- ☐ Endotracheal tubes: uncuffed sizes 2.5 - 6.0; cuffed sizes 6.0 - 8.0
- ☐ 1 14 gauge nasogastric tube

IV PACK

- ☐ 1 60cc syringe (catheter tip)
- ☐ 1 Lactated Ringer's 500cc (plastic bag)
- ☐ Lactated Ringer's 1000cc (plastic bag)
- ☐ 1 dextrose, 5% in water, 500cc (plastic bag)
- ☐ Scalp vein needle (3 each) 19 and 21
- ☐ IV infusion tubing (micro and macro drip) (1 ea) regular & pediatric
- ☐ Sterile hemostat (1 each) curved and straight
- ☐ 1 clean hemostat
- ☐ 1 towel clip
- ☐ 1 pressure pack or Holter pump
- ☐ 2 large-bore angiocaths
- ☐ 2 central line sets
- ☐ IV blood tubing - Y set
- ☐ IV catheters 16-24 gauge
- ☐ Intraosseous needles
- ☐ Volutrol IV sets or equivalent

6. EQUIPMENT INFORMATION - continued

MEDICATION PACK

- ☐ 2 morphine sulphate 10 mg. tubes
- ☐ 2 Epinephrine prepacked injectable 1:10,000
- ☐ 2 Epinephrine, 1:1,000
- ☐ 2 Aminophylline 500 mg. amps
- ☐ 4 Atropine 0.1 mg/ml-5 ml. prepacked injectable
- ☐ 2 Dextrose 50% prepacked injectable
- ☐ 6 sodium bicarbonate prepacked injectable 44.6 mg
- ☐ 3 Diazepam - 10 mg
- ☐ Needles (5 each) 18 - 25 gauge
- ☐ Syringes (3 each) 3, 5, and 10
- ☐ TB and insulin syringes
- ☐ 1 60cc needle tip syringe
- ☐ 2 $CaC1_2$ prepacked injectable
- ☐ 3 Lidocaine 100 mg-prepacked injectable
- ☐ 2 Naloxone 0.4 mg/ml
- ☐ 3 Lidocaine 2 gm/10 ml
- ☐ 4 Furosemide 10 mg/ml 2 ml/amp
- ☐ 4 Nitroglycerin tabs
- ☐ 2 Propranolol 1 mg/ml amp
- ☐ 1 Prednisolone
- ☐ 1 Sodium Succinate 1000 mg vial
- ☐ 2 Digoxin I.M. 0.5 mg/2 ml amp

SUPPLIES - OXYGEN

- ☐ 6 nasal cannulas - adult and pediatric
- ☐ 2 Kenwood type O_2 (adult, child and pediatric size)
- ☐ 2 Hudson type O_2 masks
- ☐ 6 connecting tubes
- ☐ 1 nasal catheter

SUPPLIES - DRESSINGS

- ☐ 4 Kerlix rolls
- ☐ 4 Kling
- ☐ 4 packages gauze 4x4
- ☐ 2 wrist restraints
- ☐ 2 surgical dressings
- ☐ 1 roll aluminum foil - 18" x 25', sterilized and wrapped
- ☐ 2 rolls adhesive tape - 3" wide

6. EQUIPMENT INFORMATION - continued

EQUIPMENT

- ☐ 2 stretchers - folding with restraints
- ☐ 1 long backboard
- ☐ Oxygen system to provide 8 liters per minute flow for the longest anticipated flight plus 45 minutes
- ☐ 1 suction - portable
- ☐ 2 blankets
- ☐ 1 large scissors
- ☐ Sound suppressors for each person
- ☐ BP cuff for child and adult, sphygmomanometer, and stethoscope
- ☐ Pneumatic Anti Shock Garments - adult and pediatric
- ☐ Pediatric immobilization system - pediatric backboard, KED, or equivalent
- ☐ Cardiac board
- ☐ Pulse oximeter monitor
- ☐ Blood glucose analysis system
- ☐ CO_2 detection device

BURN PACK

- ☐ 3 1,000cc normal saline (plastic pour-cap bottle)
- ☐ 1 57" x 80" sheet
- ☐ 2 pair sterile gloves
- ☐ 2 packs fluffy gauze
- ☐ 4 Kerlix rolls

PEDIATRIC PACK - To be carried when required

- ☐ 1 incubator and equipment for neonatal care
- ☐ Oxygen masks - infant and child sizes
- ☐ Nonrebreathing mask - infant and pediatric sizes
- ☐ 1 respirator
- ☐ 1 set suction catheters (pediatric size) - tonsil tip and 6F-14F
- ☐ 2 bulb syringes
- ☐ 2 DeLee suction (including 1 10 F)
- ☐ 1 self-inflating bag-valve-mask, pediatric size, with 2 mask sizes
- ☐ 1 self-inflating bag-valve-mask, infant size
- ☐ 1 silver swaddler
- ☐ 1 feeding tube 3, 5, 8 F
- ☐ Assorted oral airways (00-5)
- ☐ Pediatric Medication Dosage Chart
- ☐ Pediatric Trauma Score reference
- ☐ Nasopharyngeal airways sizes 18F-34F or 4.5-8.5mm

POISON PACK

- ☐ 2 Gastric Lavage tube
- ☐ 2 Ipecac Syrup - 30 ml
- ☐ 1 Physostigmine Salicylate 1 mg/gl, 1 ml/amp
- ☐ 1 activated charcoal - 10 gm

6. EQUIPMENT INFORMATION - continued

MISCELLANEOUS

- ☐ 4 cardboard splints or equivalent (arm and leg lengths) to include pediatric
- ☐ 4 routine suction catheters (variety of sizes)
- ☐ 2 tonsil suction tip
- ☐ 2 triangular bandages
- ☐ Cervical collars - variety of sizes for infant, child, and adult
- ☐ 1 self-inflating bag-valve-mask, adult, capable of delivering at least 96% O_2
- ☐ O_2 Key
- ☐ 2 flashlights (red lens for night flying)
- ☐ 1 suture kit
- ☐ 1 Foley Catheter set
- ☐ 1 cardiac monitor with strip readout and defibrillator with pediatric paddles
- ☐ Portable suction unit
- ☐ Obstetric pack.
- ☐ Thermal blanket
- ☐ Glasgow Coma Scale reference
- ☐ Pediatric traction splints
- ☐ Nebulizer
- ☐ Monitoring electrodes - pediatric sizes
- ☐ Small stuffed toy (desireable but not required)

B. Do you have sufficient equipment and medications to provide advanced life support procedures outlined in the standing orders signed by your physician medical director? YES ☐ NO ☐

C. Specify equipment needed or missing and your plans to obtain it:

D. Has all equipment been tested in the airborne environment to ensure that it works as designed at high altitudes and does not interfere with the operations of any aircraft in which it will be used? YES ☐ NO ☐

7. AIRCRAFT INFORMATION FOR PATIENT TRANSPORTS

A. Does the service have aircraft available 24 hours a day, 7 days a week, to provide patient transport, except when flying conditions are unsafe or the members of the service are responding to another emergency? YES ☐ NO ☐

B. Does the service own the aircraft used for transporting patients? YES ☐ NO ☐

If "NO", list below the air carrier(s) with whom the service has written agreement(s) in order to provide available transport 24 hours a day, 7 days a week, **and attach copies of agreements with this application**. If there are more than two air carrier written agreements, submit information for each on a separate page.

WRITTEN AGREEMENTS WITH AIR CARRIERS

_____	_____
Legal Name of Air Carrier	Legal Name of Air Carrier
_____	_____
Mailing Address	Mailing Address
_____	_____
City State Zip Code	City State Zip Code
_____	_____
Name of Agency Head	Name of Agency Head
_____	_____
Business Phone of Agency Head	Business Phone of Agency Head
_____	_____
Agreement Starting/Ending Date	Agreement Starting/Ending Date

C. Please list below the type of aircraft either owned by the Service or expected to be used through written agreement(s) and answer if each aircraft meets the requirements for communications, heating, lighting, pressurization, loading, and positioning.

AIRCRAFT		COMMUNICATIONS		HEATING 75^0 During All Phases	LIGHTING Adequate and with Night Curtain	PRESSURI-ZATION	LOADING STRETCHERS Rotation No More than 30^0 Roll (Longitudinal) or 45^0 Pitch (Lateral)	POSITIONING STRETCHERS Access to Head and Upper Body, 30" Headway, 12"-18" Clear Aisle at Head/Side
		Air to Air	Air to Ground					
Make	Model/Year	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								

(Use additional sheets of paper as necessary to include all aircraft used by Service.)

8. AFFIRMATION

I hereby affirm that _____(Name of Service) will comply with all rules and regulations of the Department of Health & Social Services 7 AAC 26.310 7 AAC 26.400, to include:

a) Having one or more Mobile Intensive Care Paramedics, Nurse Practitioners, Physician's Assistants, Registered Nurses, Certified Emergency Nurses, Critical Care Registered Nurses, or Physicians, who have had department-approved aeromedical training, to provide advanced life support to each patient being transported;

b) Providing a continuing medical education program in aeromedical training that will enable certified or licensed emergency medical personnel to meet state recertification requirements in specialized aeromedical patient transport topics;

c) Ensuring the completion of an approved inflight patient care form for each patient treated. The form must document vital signs and medical treatment given the patient. A copy of the completed inflight patient care form must

1) accompany the patient to the treatment facility;
2) be sent to the physician medical director; and
3) be kept by the service as a permanent record for five years.
4) If advertising, list in any advertisements the levels of licensed medical personnel for the service.

_____
Printed Name of Head of Service

Title:_____

Signature:_____

Date:_____

9. NOTARIZED STATEMENT

In the presence of a notary public, postmaster, clerk of court, judge, magistrate, state trooper, or authorized state employee, if such official is available, applicant must sign here. **I certify under penalty of perjury that the foregoing is true and accurate.**

_____ _____
Signature of Applicant Date

THIS IS TO CERTIFY that on this ___ day of _____, 200__, before me appeared _____

to me known and known to me to be the person named in and who executed the foregoing instrument and acknowledged voluntarily signing and sealing the same.

_____
Notary Public, Postmaster, Clerk of Court, Judge, Magistrate, State Trooper, or authorized State employee

My Commission Expires: _____
My Badge Number is _____